Children's Trust Fund

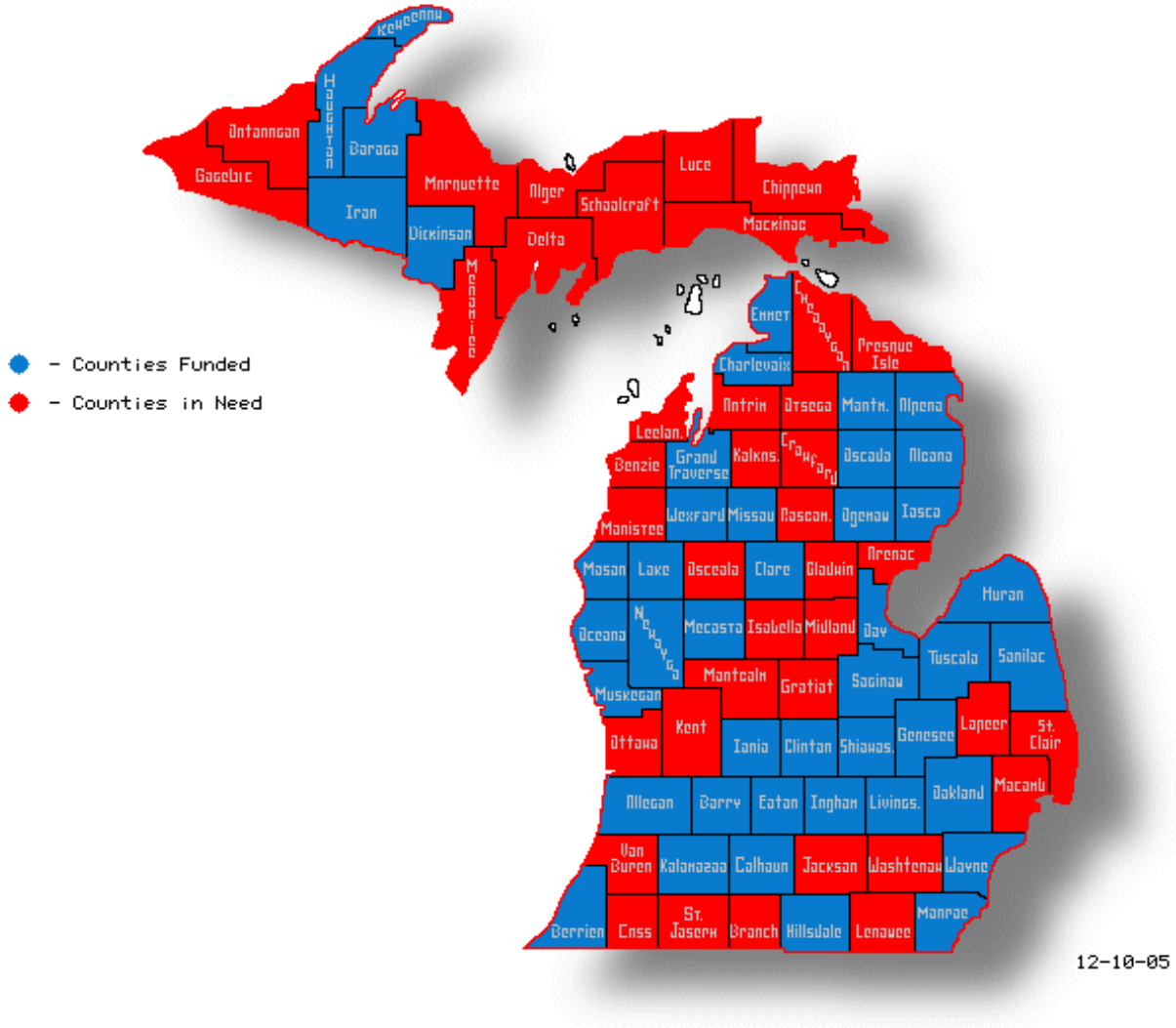
Michigan Chapter of Prevent Child Abuse America

Zero to Three Secondary Prevention RFP Pre-Proposal Conference

September 29, 2006 ~ Lansing Michigan

PowerPoint Presentation, Question & Answer Session, Supplementary Materials

Michigan's Zero to Three Secondary Prevention Initiative Programs



~Fiscal Year 2007 RFP funding priority will be given to counties in need~

The 0-3 Secondary Prevention RFP Pre-Proposal Conference, September 29, 2006-Grand Tower, Lansing

Presented By:

- The Children's Trust Fund
- The Department of Human Services
- The Department of Education
- The Department of Community Health

The RFP will:

- Expand 0-3 Secondary Prevention services to communities throughout Michigan
- Give priority to applicants that propose to expand services to counties currently not funded
- Be a statewide competition open to current and applicant grantees

Purpose of the Grants:

- To fund community based collaborative 0-3 secondary prevention projects
- To support 0-3 secondary prevention services designed to promote strong, nurturing families and prevent child abuse and neglect from occurring

Definition of Secondary Prevention:

Interventions provided for the early identification of individuals with risk factors for a specific problem or disorder. While substantiated child abuse and neglect has not taken place, the probability of abuse is greater than in the general population.

The major components of secondary prevention are:

- ✓ It is offered to a pre-defined group of families or individuals.
- ✓ It is voluntary and participants do not have an open CPS case (Category I or II disposition).
- ✓ It may be more problem-focused than primary prevention.

Population to be Served:

- Target population – Expectant families and those with children birth through three who are at risk and who meet the definition of secondary prevention.

- Risk factors are listed on page 6 of the RFP. A child or family generally has more than one risk factor.

Funding Overview:

- The application must reflect a budget to cover activities, including start-up costs if applicable, conducted from October 1, 2006 through September 30, 2007.
- Funds will be prorated and used from January 1, 2007 through September 30, 2007
- Applicants may request any amount up to $200,000.
- Funding is available to public or private, profit or non-profit organizations/agencies.
- A single fiscal agent must be identified. However multiple providers may be involved.

Funding Overview continued...

- The grant will cover a two (2) year period ending September 30, 2008 and will be fully funded in FY-08 (i.e., October 1, 2007 to September 30, 2008)

- Continued funding is contingent upon legislative appropriation, compliance with the terms of the grant agreement and continuing need for services.

Funding Requirements:

- Projects must meet the CTF definition of secondary prevention.
- Funds can not be expended for services to families who have an open CPS case (Category I or II).
- Funding for existing and/or new projects shall be used to expand secondary prevention services to communities/counties in need.
- Awards may not be used to supplant existing funds to support an ongoing project.
- There must be a documented local match of 25% of the requested funds. There is a 15% minimum cash match requirement.
- Cash match may not be federal funds (SFSC, Early On, etc.) nor be sources through the same appropriation (T.A.N.F., GP/GS, MSRP, etc.)

Funding Requirements continued …

- Projects must have a strong evaluation component that include:
  - ✓ clear program goals and objectives
  - ✓ measurable, time-framed outcomes
  - ✓ methods to assess client satisfaction
  - ✓ methods to incorporate client participation
- Only one application from counties with a population less than 500,000 may be endorsed by the Community Collaborative (CC)
- For funds to be awarded the applicant must secure the endorsement from the CC of the county or counties the project will cover

Funding Priorities:

- Will be given to applicants that propose to service counties currently not funded.
- Community profile measures will be a significant factor in the decision making process. This aspect of the review will consider whether services are targeted in communities with higher than average rates of:
  - Child abuse and neglect
  - Infant mortality
  - Poverty
  - Adult substance abuse
  - Out-of-wedlock pregnancy
  - Teen pregnancy

Funding Considerations:

- The extent to which the application demonstrates local coordination and collaboration.
- The extent to which the proposed services are integrated into a broader community plan of family supports and prevention.
- The extent to which the application has identified a clear plan for evaluating the proposed services.
- The extent to which the application for the proposed services is based on a proven program model or sound research methodology.
- Whether there is a clear process for identifying, referring, and serving families.
- Whether the application has documented agreements, including specific tasks with agencies that are integral to the success of the plan.

Administrative/ Evaluation Costs:

- No more than 15% of the requested funds may be used for administrative costs.
- Up to $10,000 of the requested funds may be budgeted for evaluation of the proposed project.
- Evaluation costs are not considered administrative costs.
- Training directly related to the provision of services or supervision of staff are not considered administrative costs.
- A portion of the requested funds may be budgeted for audit requirements.

Evaluation & Outcomes Overview:

- Summative evaluations focus on programmatic outcomes.
- Address legislative mandates.
- Examines…
- ✓ Are families better off when they exit services.
- ✓ If families acknowledge improvements in parent-child interactions.
- ✓ Objectively measure changes in parenting.

Evaluation & Outcomes:

Applications must include an evaluation plan that identifies:

- ✓ a means of assessing client satisfaction
- ✓ a means incorporating client participation
- ✓ measurable, time-framed outcomes which are integral to the comprehensive community prevention plan
- ✓ performance objectives for each outcome including how they will be measured

Grantees must also agree to participate in statewide evaluation efforts.

Evaluation & Outcomes continued...

- Each applicant will also be required to measure how the project will impact statewide goals and objectives (listed on page 9 of the application).
- Funded home visitor programs may be required to participate in the Program Information Management System (PIMS) data collection project.

Zero to Three Program Indicators:

- Critical measures are outlined.
- Created to address outcomes and accountability for programs and services.
- Systematically collect data in the aggregate for legislative reporting purposes.
- Encompass both the process and outcomes of initiative.
- Demonstrates that impacts are being made on the population served.
- Pragmatically, strengthens support for increased funding.

Adult Adolescent Parenting Inventory *the* AAPI-2:

- Is a measure used to assess the parenting attitudes of adults and teens who are either parents or expectant parents.
- Is used to measure aspects of parenting common to most secondary prevention programs regardless of curriculum.
- Is scored and maintained online.
- Training and TA will be provided to those applicants awarded funding.

CPS Central Registry *the* 3-1b Category I & II Dispositions:

- The 3-1b form is a register of all children served by your project and is submitted with the 4th Quarter Report each FY.
- The 3-1b is used to evaluate family involvement with CPS.
- CPS involvement, or non-involvement, is a fundamental outcome in the 0-3 secondary prevention initiative.
- Eligible families may not have a open Category I or II CPS case per the enabling legislation.

The Zero to Three Data Collection Form Addresses:

- Who we're serving and demographic variables.
- That participants are receiving recommended services.
- That additional services that are provided (i.e, referrals).
- Accountability.
- Client satisfaction.
- Focuses primarily on the process components of programs.
- Is used by Grant Monitors to assess desired outcomes.
- Is submitted with each quarterly report.

Reporting Requirements:

- Grantees are required to submit quarterly progress reports that summarize and document all project activities and expenditures for the period covered.
- Reports are due: January 20th, April 20th, July 20th, and October 20th.
- An annual evaluation report is also required and must be submitted by December 20th each fiscal year.

Grant Agreement Requirements:

- Demonstrates an impact upon the population served
- Collecting and processing program utilization data
- Participating in evaluation efforts as required
- Participate in on-site visits as required
- Provide technical assistance to other communities in implementing a similar project
- Maintaining a relationship with the local CC
- Submit required reports and documentation
- Participating in surveys conducted
- The agency may be required to comply with a OMB A-133, A-122 (governmental agencies) or A-87 audits (non-profits).

Responsibilities of the Community Collaborative:

- **Develop or update the comprehensive community prevention plan.**
  - ✓ Includes a review of the program models of service delivery for the target population that have demonstrated proven impact on the risk factors of children and their families, and that meet the identified needs of the community.
- **Assist in the identification of local match funds.**
- **Assist in the selection of the outcomes the application will address.**
- **Review the application and endorse the applicant to provide services to the county/counties proposed.**

Guidelines for Developing a Comprehensive Community Prevention Plan:

- Establish a vision for the community prevention plan with special attention to secondary prevention strategies.
- Determine the extent the comprehensive vision is supported through existing services.
- Identify the interrelationships between existing programs that enhance service delivery and the gaps between the vision and current services.
- Develop an action plan to integrate planned secondary prevention efforts and/or enhancements to reach the comprehensive approach.
- Identify local partners who support the comprehensive approach through their resources.

Technical Assistance Provided:

- The Children's Trust Fund (CTF) will take the lead for technical assistance in the area of best practices for family support and secondary prevention models.
- The close date for bidder questions/clarifications is 3:00 PM October 2, 2006.

Anticipated Timeline:

- Applications must be received on or before 3:00 PM October 13, 2006
- Review of applications will be completed on October 24, 2006
- Announcement/Award Notification by November 6, 2006
- Effective Start Date: January 1, 2007

GOOD LUCK!!


Children's Trust Fund
Michigan Chapter of Prevent Child Abuse America

Zero to Three Secondary Prevention

FY-07 Request for Proposal Conference

September 29, 2006 Lansing, MI. 48933

Posted Q & A Session

The deadline for bidder questions was Monday October 2, 2006.

Q. Who is eligible to bid in the 0-3 RFP process?

A. The RFP is a statewide competitive bid open to ALL applicants. While priority will be given to bids that propose to provide 0-3 Secondary Prevention services (by current and applicant grantees) in counties currently not funded , current 0-3 providers may submit a bid to expand services to for example, a community within their county that is currently not served and in need. (also refer to the definitions of enhanced and expanded on pages 4-5 in the RFP)

Q. What is the evaluation line item in the budget?

A. The maximum of $10,000 is the allowable expense for the local evaluation due in Dec. of each year. An outside evaluation is not a requirement, but some grantees use this allowance for contracting an independent evaluator. A guidance document for this annual evaluation will be attached with this Q & A document. There is not a required format.

Q. Are all of the indicators required for each site? Can they be modified?

A. All of the statewide indicator provided in the RFP entitled "Zero to Three Secondary Prevention Initiative Program Indicators" are required to be implemented and measured. They may not be modified. There are currently 37 Zero to Three secondary prevention sites in Michigan. The programs utilize a variety of service delivery models. The statewide indicator along with the Adult/Adolescent Parenting Inventory (AAPI) allow for a standardized evaluation of the projects.

Q. Can a local site use the information gained from the AAPI locally?

A. Yes. We would expect that the local site would utilize all evaluation data to make informed decisions about this program and the continuum of services for parenting and early childhood programs in the area. Additionally, any evaluation data collected for statewide efforts can be used for local evaluation reporting external to Zero to Three requirements.

Q. Can a local site chose some of their own indicators?

A. Yes. Many sites have a particular focus interest, such as teen parent's graduation rates or newborn weight. It is helpful to set a target for the area, implement the intervention and adjust the target based on data gained.

Q. Do we need to budget training and materials for the AAPI?

A. No. Michael Gillespie is the evaluation consultant for the 0-3 Secondary Prevention Initiative. He will provide the AAPI training. Your budget may be used to provide other needed trainings. The AAPI forms will be provided for you. The submission of the administrations is on-line and training will be provided at no cost .

Q. Can the program be a new component of an existing project funded by 0-3 secondary prevention?

A. Yes. If it is to expand services to new area (also refer to the definitions of enhanced and expanded on pages 4-5 in the RFP). The new funding is available to expand services to new geographic areas. This funding may not be used to supplant an existing program.

Q. Expand not enhance?

A. Please refer to the definitions on page 4-5. The "Priorities for Funding" section on page 19 may also be helpful.

Q. Is this supposed to be home visiting model? We already have home visiting but not 0-3 funded. We need to help support this, not have a different home visiting program.

A. Any program needs to be intergraded in the community prevention plan. This needs to be explained in your narrative.

Q. Which prevention plan are you referring to?

A. Each community collaborative or the Child Abuse and Neglect prevention council has a comprehensive prevention plan. (see contact information in RFP attachment) If you are having difficulty locating those plans, you may contact Jeff Sadler at CTF for assistance.

Q. Should our budget reflect the match?

A. Yes. Detailed clarification in the RFP in attachment. These are in an excel format.

Q. I am concerned about the time line and getting the "Prevention Plan" in hand.

A. It should be available through the local CC. If you are unable to secure this, document the attempts made. Include that documentation in your grant application narrative.

Q. How can we secure the match dollars within this timeline? What documentation are you looking for and how much weight is given to this area?

A. Page 18 outlines the match requirements. Documentation of letters of approval for secured, or intend to secure match will be helpful. Status of match dollars is one component of the 10 points available for this area.

Q. Is rent a match?

A. Yes. Rent represents in-kind match.

Q. Please explain the matching funds statement on page 7 of the RFP. What does "10% in-kind minimum" mean?

A. There is a minimum match requirement of 25%. In-kind contributions <u>may not</u> exceed 10%. A greater than 25% match may be required to cover the total program costs. Be sure to reflect this in the budget.

Q. Does the local match have to remain constant (over the life of grant funding)?

A. Yes. The match must be a constant match throughout the years of funding, although the funders may change (25% minimum; in-kind not to exceed 10%). We understand applicants can not predict the future. Adjustments to the grant award have been made in ratio to the fluctuation of match funds. This is done through grant amendment with your grant monitor and with the approval of CTF.

(continued), In the RFP on page 18 instruction clarify the expectable match funds. You may not use match dollars from state school aid funding such as Michigan School Readiness, or Great Parents/Great Start. Also not, federal funding may not be used as match funding, such as Early On, Head Start, Medicaid or TANF.

Q. Please explain page 8, bullet 7, "provide TA to other communities".

A. This is not expected to be formal TA formats. We are hoping to create an environment of sharing best practices and helpfulness. This is not intended to be a burden of time or money on the sites, however, willingness to aid and support others in a statewide system always encouraged.

Q. What is not part of the 10 page limit referenced in the RFP?

A. Anything that is listed as an attachment is not part of the 10 pages. It will be helpful to have your document paginated.

Q. Is there an expectation that we will "exit" a family each year?

A. No. Families complete service when the risk factors have been mitigated, until their youngest child turns four, there is a substantiation of Category I or II from Child Protective Services, or the family says they wish to discontinue service. The length of time a family stays in services varies greatly, however, the evaluation tool does not dictate how long service last.

Zero to Three Secondary Prevention
Data Collection Definitions for
Monitoring and Evaluation Reporting

The purpose of this document is to provide guidance and definitions for the fields contained on the Data Collection Form (*Revised 01/04/06*). The Data Collection Form, formerly the Program Register, is used by the Zero to Three Secondary Prevention Grant Monitors to examine the progress of both the process and outcomes of grantees. Both process and outcomes are important in program monitoring; further, each of these pieces lends to the larger evaluation of the Initiative through the *Zero to Three Secondary Prevention Initiative Program Indicators*.

Formative evaluations focus on the processes of a program and answer such questions as:

- Who are we serving?
- What are the demographic characteristics of who we are serving?
- Are participants receiving recommended services?
- What other services are we providing?
- Are we doing what we said we would do?
- Are participants satisfied with services?

Summative evaluations focus on the end-results and outcomes of the program to meet the intent of the legislation, and focus on such questions as:

- Are participants better off when they leave our program?
- Do participants report improvements due to our service?
- Have objectively measurable changes been observed for our participants?

The Data Collection Form focuses primarily on the process components of programs. The outcome evaluation is using the Adult Adolescent Parenting Inventory (AAPI-2) as well as the 3-1B form which is used to evaluate participant involvement in Child Protective Services.

Therefore, the following definitions and Data Collection Form are intended to inform the process portion of the Zero to Three Secondary Prevention Initiative Evaluation.

The New Data Collection Form: Electronic Version

The new Data Collection Form provided is familiar in format but is electronically enhanced to compute all percentages and frequencies accurately. The only cells in which data may be entered or manipulated are those in the 1st, 2nd, 3rd, and 4th Quarter Columns. The Year to Date (YTD) and all percentages cells (%) will be calculated for you. Further, the form is locked and protected so no amendments or changes can be made to the format. This is to ensure that everyone is using the same form and collecting data the same way. With increased accountability requirements, the Initiative needs to ensure that data is being collected uniformly.

Attachment A is a copy of the new Data Collection Form. This is solely for reference; please use the electronic version for reporting to your grant monitor.

Note: Forms not completed correctly will be returned by your monitor for revisions.

Duplicated vs. Unduplicated Counts

For consistency, definitions offered below are to clarify the difference between a duplicated and unduplicated count. For the majority of the data indicators in the Data Collection Form, the counts will be unduplicated. Items 2A, 2E, 2G, 2I, and 2J are duplicated counts.

Duplicated refers to one person, family, child, pregnant woman, etc. being counted more than once for a given period of time. For example, if the majority of families served are served over all four quarters of a grant year, and recorded as served in the appropriate manner, if the number of families served across all four quarters were added this count would be duplicated. It is duplicated because the majority of families are being served in all 4 quarters, and hence counted as served in all four quarters. The total number of families served, if added across the 4 quarters would be inflated close to a factor of 4. It is for this reason that *duplicated counts are never added*.

Unduplicated refers to the person, family, child, pregnant woman, etc. being counted only once for a given period of time. For example, the number of newly enrolled families is only counted for the quarter in which they officially enter services. That is, their enrollment will be counted only once in the 4 quarters of the grant year. If the numbers of families enrolled for each quarter are added, and each family enrolled that year is counted once, then the total number of families enrolled across the 4 quarters is unduplicated and can provide an accurate number of the newly enrolled families for the previous grant year.

Data Collection Form Indicator Definitions

Section 1: Contact Information

Name of Program/Agency: Fill in the name of the program **and** the agency holding the Zero to Three Secondary Prevention grant.

Counties Served: List all of the counties served by the grant where services are provided.

Program Telephone Number: Fill in the telephone number for the grantee contact person

Quarter of the Fiscal Year: Indicate the quarter of the report you are submitting.
1st Quarter – October 1 through December 31
2nd Quarter – January 1 through March 31
3rd Quarter – April 1 through June 30
4th Quarter – July 1 through September 30

Date Forwarded: Fill in the date this form is being sent to your grant monitor.

Completed By: Provide the name of the person completing the form.

Section 2: Participant Data

This section is intended to document the number of families and children served as well as their status in the program or when they exited services. Please complete only the column that corresponds to the quarter for which the report is intended, highlighted in Section 1.

2A. Number of Families from Previous Quarter Continuing in Services

For each quarter, enter the number of families who remain in service *from the previous quarter*. If this is the first quarter of the grant year, enter the number of families remaining in services from the 4th quarter of the previous grant year. *This is a new field starting in the first quarter of Grant Year 2006*.

Data Entry Rules for 2A:
- Record the number of families continuing in services from the previous quarter
- The number entered in 2A for each quarter should equal the total number of families served less the number of families who aged-out, the number of families who completed the service, the number of families transitioning to other services and the number of families who dropped out of services in the previous quarter: [2A = 2E – (2K + 2L+ 2M + 2Na + 2Nb + 2Nc + 2Nd)].

2B. Number of Families Screened

Screening is the primary step to determine eligibility for your program. Each screening of one family may be counted. If a family is screened more than once during the quarter, ***count this family only once***. If the same family is screened in different quarters, then the family may be counted as screened in each quarter.

Data Entry Rules for 2B:
- Record the unduplicated number of families screened for each quarter in the appropriate box.

- The number screened must be greater than or equal to the number of families enrolled each quarter: (2B ≥ 2D).

2C. Number of Families Assessed

Assessment is the initial step in determining the needs of the children and families necessary to develop service plans. If one family is assessed twice in the same quarter, ***count this family only once***. If the same family is assessed in different quarters, then the family may be counted as assessed in both quarters.

Data Entry Rules for 2C:

- Record the unduplicated number of families screened for each quarter in the appropriate box.
- The number assessed must be greater than or equal to the number of families enrolled each quarter: (2C ≥ 2D).

2D. Number of Newly Enrolled Families

Enrollment is the formal entering in to services. In other words, the family is officially served[1]. If a family is enrolled, exited, and enrolled again in the same quarter, the family can only be counted once. However, if the family is enrolled and ***officially*** exited in one quarter, and then re-enrolls in a subsequent quarter, they may counted twice. This is the only time when a family may be counted twice in 2D.

Data Entry Rules for 2D:

- Record the unduplicated number of families enrolled for each quarter in the appropriate box.
- The number of families enrolled must not be greater than or equal to the number of families served, unless the number of families continuing from the previous quarter is zero: (2D < 2E).

2E: Number of Families Served

The number of families served is the number of families receiving Zero to Three Secondary Prevention Initiative funded services for the quarter. This number is the **total number of families served** regardless if they discontinued, aged-out, completed, or left services later in the quarter. The family was still served[1].

Data Entry Rules for 2E:

- Record the number of families served for each quarter in the appropriate box.
- The number of families served is the number of families continuing from the previous quarter plus the newly enrolled families: (2E = 2A + 2D).

2F: Number of Newly Enrolled Children Ages 0-3

Newly enrolled children should be recorded in this section. Enrollment is the formal entering in to services. In other words, the child is officially served. If a child is enrolled, exited,

[1] Services funded through the Zero to Three Secondary Prevention Initiative (0-3) must serve families of very young children who are at-risk of child abuse and/or neglect. As the initiative has evolved through the years, the need for clarification on the definition of 0-3 eligibility is recognized. Families and children are eligible to begin services prenatally and continue until services are no longer necessary or up to the child's age of 48 months.

The eligible population includes expectant parents, families whose children meet the age requirement and families who meet the definition of "secondary prevention" as outlined by the enabling legislation[1]. Families who have an open Child Protective Services case with a Category I or II Disposition cannot be served through Zero to Three Secondary Prevention Services.

and enrolled again in the same quarter, the child can only be counted once. However, if the child is enrolled and ***officially*** exited in one quarter, and then re-enrolls in a subsequent quarter, they may be counted twice. This is the only time when a child may be counted twice in 2F.

Data Entry Rules for 2F:
- Record the unduplicated number of children enrolled for each quarter in the appropriate box.
- The number of children enrolled must not be greater than the number of children served: (2F < 2G).

2G: Total Number of Children Ages 0-3 Served

The number of children served is the number of children receiving Zero to Three Secondary Prevention Initiative funded services for the quarter. This number is the **total number of children served** regardless if they discontinued, aged-out, completed, or left services later in the quarter. The child was still served.

Data Entry Rules for 2G:
- Record the number of children served for each quarter in the appropriate box.

2H. Total Number of Newly Enrolled Pregnant Women

If applicable, the number of pregnant women newly enrolled should be counted and entered. Enrollment is the formal entering in to services. In other words, the woman is officially served. If a pregnant woman is enrolled, exited, and enrolled again in the same quarter, they can only be counted once. However, if the woman is enrolled and ***officially*** exited in one quarter, and then re-enrolls in a subsequent quarter, she may counted twice. This is the only time when a pregnant woman may be counted twice in 2H.

Data Entry Rules for 2H:
- Record the unduplicated number of pregnant woman newly enrolled for each quarter in the appropriate box.
- The number of pregnant women enrolled must not be greater than the number of pregnant women served: (2H < 2I).

2I: Total Number of Pregnant Women Served

The number of pregnant women served is the number of pregnant women receiving Zero to Three Secondary Prevention Initiative funded services for the quarter. This number is the **total number of pregnant women served** regardless if they discontinued aged-out, completed, or left services later in the quarter. The woman was still served.

Data Entry Rules for 2I:
- Record the total number of pregnant women served for each quarter in the appropriate box.

2J: Number of Families Served with 3 or More Risk Factors

Provide the number of families served with 3 or more risk factors. The list of risk factors is included in Attachment B at the end of this document and is the same list used in the initial application for Zero to Three funding. The number of families served with 3 or more risk factors is the number of families receiving Zero to Three Secondary Prevention Initiative funded services for the quarter with 3 or more risk factors. This number is the **total number of families served** with 3 or more risk factors regardless if they discontinued, aged-out, completed, or left services later in the quarter. The family was still served. The number of families served with three or more risk factors

is a sub-set of the total number of families served for the quarter and should not exceed this number.

Data Entry Rules for 2J:
- Record the number of families with 3 or more risk factors served for each quarter in the appropriate box.
- The number of families with 3 or more risk factors served should not exceed the total number of families served for the quarter as it is a sub-set of this number (2J ≤ 2E).

2K: Number of Families who "Aged-Out"

Report the number of families who, during the relevant quarter, exited services because the youngest child enrolled in Zero to Three Secondary Prevention funded services is over three years of age (4 years of age). Because of the guiding legislation, 0-3 services can only be provided to families with children ages birth to three. These families should only be counted if they have been screened, assessed, and officially enrolled in 0-3 funded services, then aged out. If the families were not officially enrolled, do not count them in this section.

Date Entry Rules for 2K:
- Record the number of families exiting services because the youngest child is over three years of age

2L: Number of Families Completing Service

Report the number of families successfully completing their service plan and exiting in the relevant quarter. Completing services means their service plans were fulfilled and the families' needs/goals/outcomes have been met. These families should only be counted if they have been screened, assessed, and officially enrolled in 0-3 funded services, and then completed services to the family's satisfaction. If the families were not officially enrolled, do not count them in this section.

Date Entry Rules for 2L:
- Record the number of families exiting services because they have successfully completed their service plan.

2M: Number of Families Transitioned to Other Services

Provide the number of families who exited services and transitioned to a service where their needs will be better addressed. These families should only be counted if they have been screened, assessed, and officially enrolled in 0-3 funded services, and then transitioned out. If the families were not officially enrolled, do not count them in this section. These families have not completed 0-3 services; rather, they need to move to more appropriate services. This data should also include families moving out of your service area *who have been referred to services in their new area of residence*.

Date Entry Rules for 2M:
- Record the number of families transitioning to other services.

2N: Number of Families who Dropped Out of Services

Report the number of families who dropped out of services because they are no longer interested in the service, they are unable to be located, or for other reasons. These families should only be counted if they have been screened, assessed, and officially enrolled in 0-3 funded services, and then dropped out. If the families were not officially enrolled, please do not count them in this section.

For 2Na, report the number of families who are no longer interested in receiving 0-3 funded services. These families should express that they no longer wish to participate either with words or actions per your program's written policy. For 2Nb, report the number of families no longer able to be contacted or located by the program. These families did not express interest in leaving the program, not were they transitioned to other services, aged out, or completed services. For 2Nc and 2Nd, list other reasons you may have for families dropping out of services and provide the relevant data.

Data Entry Rules for 2N:

- 2Na = The number of families no longer interested in services
- 2Nb = The number of families no longer able to be contacted by the program
- 2Nc = Other reasons your program has for families dropping out of services not covered by other options and relevant data
- 2Nd = Other reasons your program has for families dropping out of services not covered by other options and relevant data

Section 3: Race/Ethnicity of Children Served

Section 3 collects data on the number of children served, per quarter, based on racial and ethnic demographics. The number of children served should be place into one of the 5 provided racial/ethnic categories *based on the family-identified race or ethnicity*. No judgments should be made by program staff about the validity of the choice by the family of their race/ethnicity.

A multi-racial category has been added to account for those participants who may fall in to more than one race and or/ethnic category. According to the US Census Bureau[2], a multi-racial person can chose to identify with two or more race and/or ethnic groups according to their personal identity.

The number of children served is the number of children receiving Zero to Three Secondary Prevention Initiative funded services for the quarter. This number is the **total number of children served** regardless if they discontinued, aged-out, completed, or left services later in the quarter. The child was still served.

Data Entry Rules for Section 3:

- The number of Black or African-American, Hispanic or Latin-American, White or Caucasian, Multi-Racial, and Other Race/Ethnicity should equal the number of Children Served in 2G. This number will be checked with the following method: (Section 3 = #Black or African American + #Hispanic or Latin American + #White or Caucasian + #Multi-Racial + #Other = 2G)
- Include the other races/ethnicities served in the space provided

Section 4: Service Provided

This section reports the number of activities/services/events provided by the grantee in the quarter. This section does not count the number of families or children served, but the number of actual services provided. One unit of service is counted once.

[2] http://www.census.gov/population/cen2000/phc-2-a-B.pdf

4A: Home Visits – Initial and subsequent visits in the family home.
4B: Parenting Classes – Education or skill-building classes and curriculum on child development, parenting, local family resources, or other topics related to the prevention of child maltreatment.
4C: Parent Support Groups – Meetings of peers to support each other and exchange information and ideas.
4D: Service Coordination – Coordinate and manage supports and services for the family and children based on identified needs.
4E: Child Care Services – Care services provided to children in the absence of a parent.
4F: Respite Care Services – Care services provided for children in short intervals to allow the parent/caregiver a break from parenting to enhance the positive and safe functioning of a family.
4G: Transportation – Providing transportation services to a client or group of clients in order to facilitate access to needed services and supports.
4H: One-on-One Counseling – Therapeutic interventions aimed at the mental health of families/individuals; Counseling meetings home-based or otherwise focused on the needs of the family/individual.
4I.1: Other Service: Phone Contacts: Provide the number of telephone contacts, both in-coming, and outgoing, provided by your program with the distinct focus on secondary prevention activities.
4I.2: Other Service: Developmental Newsletters – Provide the number of developmental newsletters disseminated (number of mailings) per quarter.
4I.3: Other Service: Developmental Assessments/Screenings – Provide the number of developmental assessments provided per quarter. This is the number of developmental assessments/screenings provided, not the number of children receiving the assessments/screenings. Item 5E counts the number of children receiving these assessments/screenings.
4I.4: Other Services: Please aggregate other services not listed above and provide their names in the space provided.

Section 5: Outcome Data

This section collects data on the number of families or children served who receive certain service provisions. These indicators base their calculation on the total number of families served (2E) or the total number of children ages 0-3 served (2G) unless otherwise noted.

5A: Number and percentage of families who have a primary health care provider

Report the number of families served in the quarter who have identified a primary health care provider for their family. This should be *beyond an awareness* of a doctor or physician or other provider; it should be the identified person or agency where the family *actually receives* health services.

Data Entry Rules for 5A:
- Report the number of families served with a primary health care provider
- The number of families in 5A may not be more than the number of families reported in 2E: (5A ≤ 2E)
- The percentage will automatically be calculated

5B: Number and percentage of children who are up-to-date with age-appropriate immunizations

Record the number of children served up-to-date with age-appropriate immunizations required by the American Academy of Pediatrics (AAP; www.aap.org). The 2005 AAP recommended immunization schedule is provided as Attachment C. Within reasonable and

best efforts, the Michigan Childhood Immunization Registry (MCIR; www.mcir.org) should be used to verify immunization status. If the MCIR cannot be accessed, other means, including parent report, may be used. Please contact your grant monitor for technical assistance.

Data Entry Rules for 5B:
- Report the number of children served up-to-date with age-appropriate immunizations
- The number of children in 5B may not be more than the number of children reported in 2G: (5B ≤ 2G)
- The percentage will automatically be calculated

5C: Number and percentage of 0-3 age children who are up-to-date with well-child visits

Record the number of the children receiving the recommended AAP Preventive Pediatric Health Care (well-child visits) in the given quarter. The Recommendation for Preventative Pediatric Health Care (RE9535) is provided as Attachment D.

Data Entry Rules for 5C:
- Report the number of children served who are up-to-date with well-child visits
- The number of children in 5C may not be more than the number of children reported in 2G: (5C ≤ 2G)
- The percentage will automatically be calculated

5D: Number and percentage of pregnant women who received the recommended number of prenatal visits

Record the number of pregnant women served who received the recommended number of prenatal visits by the American College of Obstetricians and Gynecologists (ACOG; www.acog.org) during the given quarter. The recommended prenatal visit schedule for a typical 40 week pregnancy is provided in Attachment E. Please contact the ACOG or the Michigan Department of Public Health for more information.

Data Entry Rules for 5D:
- Report the number of pregnant women served who are receiving the recommended number of prenatal visits for the given quarter
- The number of women in 5D may not be more than the number of women reported in 2I: (5D ≤ 2I)
- The percentage will automatically be calculated

5E: Number and percentage of 0-3 age children who participated in developmental screening during the quarter

Record the number of children whose development was assessed during the quarter. It is understood that not all children will be eligible for a developmental screening each quarter, so numbers may not include all the children ages 0-3 served. The intensity of screenings should follow the timeline provided with the screening tool each grantee is using. For example, the Ages and Stages Questionnaire, a common tool, has 19 screenings available from birth to 4 years of age, and is flexible to be used at many different intervals.

As in item 4I.3, the terms assessment and screening are interchangeable for developmental evaluation activities.

Data Entry Rules for 5E:
- Report the number of children served who participated in developmental screening for the given quarter

- The number of children in 5E may not be more than the number of children reported in 2G: (5E ≤ 2G)
- The percentage will automatically be calculated

5F: The number and percentage of 0-3 age children who met age-appropriate developmental milestones

Record the number of children who received a developmental screening in the quarter and met the developmental milestones for their age group within the normal or above normal ranges. This number is based on the number of children who received a developmental screening in the quarter, not all the children served in the given quarter.

Data Entry Rules for 5F:

- Report the number of children who received a developmental screening in the quarter and met age-appropriate developmental milestones
- The number of children in 5F may not be more than the number of children reported in 5E: (5F ≤ 5E)
- The percentage will automatically be calculated

5G: Number and percentage of 0-3 age children who did not meet age appropriate developmental milestones

Record the number of children who received a developmental screening the quarter and *did not meet* developmental milestones for their age group. This number is based on the number of children who received a developmental screening in the quarter, not all children served.

Data Entry Rules for 5G:

- Report the number of children who received a developmental screening in the quarter and did not meet age-appropriate developmental milestones
- The number of children in 5G may not be more than the number of children reported in 5E: (5G ≤ 5E)
- The number reported in 5G, when added to the number reported in 5F, must equal the number reported in 5E: (5G + 5F = 5E)
- The percentage will automatically be calculated

5Ga: Number and percentage of children with a suspected developmental delay who were referred to appropriate services

Record the number of children for the quarter who received a developmental screen, did not meet their age-appropriate development, and were referred for appropriate developmental services. This number is based on the number of children who did not meet their developmental milestone, not the total number of children receiving screens nor the total number of children served.

Data Entry Rules for 5Ga:

- Report the number of children who received a developmental screening in the quarter and did not meet age-appropriate developmental milestones, and hence were referred to appropriate services
- The number of children in 5Ga may not be more than the number of children reported in 5G: (5Ga ≤ 5G)
- The percentage will automatically be calculated

5Gb: Number and percentage of families whose children were referred for developmental services that followed through with the referral

Record the number of referrals for developmental services for which families followed through with the referrals. This number is based on the number of children/families referred for developmental services, not the number of children who did not meet developmental milestones, or those screened or the total number of children served.

Data Entry Rules for 5Gb:

- Report the number of children who received a developmental screening in the quarter and did not meet age-appropriate developmental milestones, and hence were referred to appropriate services and followed through with the referral
- The number of children in 5Gb may not be more than the number of children reported in 5Ga: (5Gb ≤ 5Ga)
- The percentage will automatically be calculated

Section 6: Participant Satisfaction

Participant satisfaction surveys are not required for every quarter, but at least once during the grant year as part of the locally-based program evaluation. Section 6 is intended to organize data on participant satisfaction with 0-3 funded services as well as participant reports of impact.

6A: Number and percentage of families sent the satisfaction survey

Report the number of families served who were sent/given the satisfaction survey for the given quarter. If no families received the survey in the quarter, enter a zero (0) and do not proceed with the remainder of the section. This is a new data field starting in Grant Year 2006.

Data Entry Rules for 6A:

- Report the number of families receiving the satisfaction survey for the given quarter.
- The number of families in 6A may not be more than the total number of families served as reported in 2E: (6A ≤ 2E)

6B: Number and percentage of families responding to the satisfaction survey

Report the number of families served who received a satisfaction and who completed and returned the survey for the given quarter. This number is based on the number of families receiving a survey, not on the total number of families served. This is a new data field starting in Grant Year 2006.

Data Entry Rules for 6B:

- Report the number of families receiving the satisfaction survey *and* returning the completed survey for the given quarter.
- The number of families in 6B may not be more than the number of families receiving surveys as reported in 6A: (6B ≤ 6A)

6C: Number and percentage of families who were satisfied with 0-3 services

Report the number of families who received and returned the satisfaction survey and who were served in 0-3 services. This number is based on the number of families who received, completed, and returned the satisfaction survey, not on the number of families served for the quarter.

Data Entry Rules for 6C:

- Report the number of families receiving the satisfaction survey who returned the completed survey for the given quarter and indicated satisfaction with 0-3 services.
- The number of families in 6C may not be more than the number of families receiving and returning surveys as reported in 6B: (6C ≤ 6B)

6D: Number and percentage of families who reported that their parenting skills improved as a result of the 0-3 service(s)

Report the number of families who indicated an impact on their parenting skills by participation in 0-3 services. This number is based on the number of families who received and returned a complete satisfaction survey, not on the total number of families served.

Data Entry Rules for 6D:

- Report the number of families receiving the satisfaction survey *and* returning the completed survey for the given quarter who indicated that the 0-3 services in which they participated improved their parenting skills
- The number of families in 6D may not be more than the number of families receiving and returning completed surveys as reported in 6B: (6D ≤ 6B)

Attachment A:

Data Collection Form

Note: This is provided as a reference, please use the Electronic Microsoft Excel version

0-3 Secondary Prevention Programs
Data Collection Form
(formerly known as the program register)
Fiscal Year 2005-2006

1. Contact Information

CTF Grant Monitor Approval_____

Name of Program/Agency:_____ County(ies) Served:_____

Program Telephone Number: ( ) _____ Quarter of the Year: ____ 1st ____ 2nd ____ 3rd ____ 4th

Date Forwarded: Completed By:_____
(Print or Type Name)

2. Participant Data (for all programs/services funded by the 0-3 grant)	**Quarterly Services & Year-To-Date Totals**							
	1st	YTD	2nd	YTD	3rd	YTD	4th	YTD
A. Number of Families from Previous Quarter Continuing in Services*								
B. Number of Families Screened		0		0		0		0
C. Number of Families Assessed		0		0		0		0
D. Number of Newly Enrolled Families		0		0		0		0
E. Total Number of Families Served *								
F. Number of Newly Enrolled age 0-3 Children		0		0		0		0
G. Total Number of Children age 0-3 Served *								
H. Number of Newly Enrolled Pregnant Women (if applicable)		0		0		0		0
I. Total Number of Pregnant Women Served (if applicable) *								
J. Number of Families Served with 3 or more Risk Factors*								
K. Number of Families who "aged out"		0		0		0		0
L. Number of Families Completing Service		0		0		0		0
M. Number of Families Transitioned to Other Services		0		0		0		0
N. Number of Families who Dropped Out of Services								
a. Number of families who are no longer interested in service		0		0		0		0
b. Number of families that are unable to be located		0		0		0		0
c. Other (please specify) _____		0		0		0		0
d. Other (please specify) _____		0		0		0		0

3. Race/Ethnicity of Children Served		1st		2nd		3rd		4th	
Race: Black or African-American	Child								
Race: Hispanic or Latin-American	Child								
Race: White or Caucasian	Child								
Race: Multi-Racial	Child								
Other Race (Please Specify): _____	Child								

4. Services Provided	1st	YTD	2nd	YTD	3rd	YTD	4th	YTD
A. Home Visits		0		0		0		0
B. Parenting Classes		0		0		0		0
C. Parent Support Groups		0		0		0		0
D. Service Coordination		0		0		0		0
E. Child Care Services		0		0		0		0
F. Respite Care Services		0		0		0		0
G. Transportation		0		0		0		0
H. One-on-one counseling		0		0		0		0
I.1 Other Service: Phone Contacts		0		0		0		0
I.2 Other Service: Developmental Newsletters		0		0		0		0
I.3 Other Service: Developmental Assessments/Screenings		0		0		0		0
I.4 Other Service:(Specify):		0		0		0		0

5. Outcome Data		1st		2nd		3rd		4th	
A. Number and percentage of families who have a primary health care provider	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
B. Number and percentage of 0-3 age children who are up-to-date with age-appropriate immunizations	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
C. Number and percentage of 0-3 age children who are up-to-date with well-child visits	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
D. Number and percentage of pregnant women who received the recommended number of prenatal visits	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
E. Number and percentage of 0-3 age children who participated in developmental screening during the quarter	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
F. Number and percentage of 0-3 age children who met age-appropriate developmental milestones	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
G. Number and percentage of 0-3 age children who did not meet age appropriate developmental milestones	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
a. Number and percentage of 0-3 age children with a suspected developmental delay who were referred to appropriate services	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
b. Number and percentage of families who followed through with the referral(s) to appropriate developmental services	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
6. If a participant satisfaction survey was completed this quarter, complete the following:									
A. Number and percentage of families sent the satisfaction survey	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
B. Number and percentage of families responding to the satisfaction survey	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
C. Number and percentage of families who were satisfied with 0-3 services	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
D. Number and percentage of families who reported that their parenting skills improved as a result of the 0-3 service(s)	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	

<u>Attachment B</u>:

40 Risk Factors for Families with Children Zero through Three

Note: This was provided in the original application for Zero to Three Secondary Prevention Funding.

POPULATION TO BE SERVED

The target population is **families with children from 0-3 who are at risk**, who meet the secondary prevention definition, and are not on the active Child Protective Services caseload of the Department of Human Services. Risk factors are listed below; a family may have one or more of these risk factors.

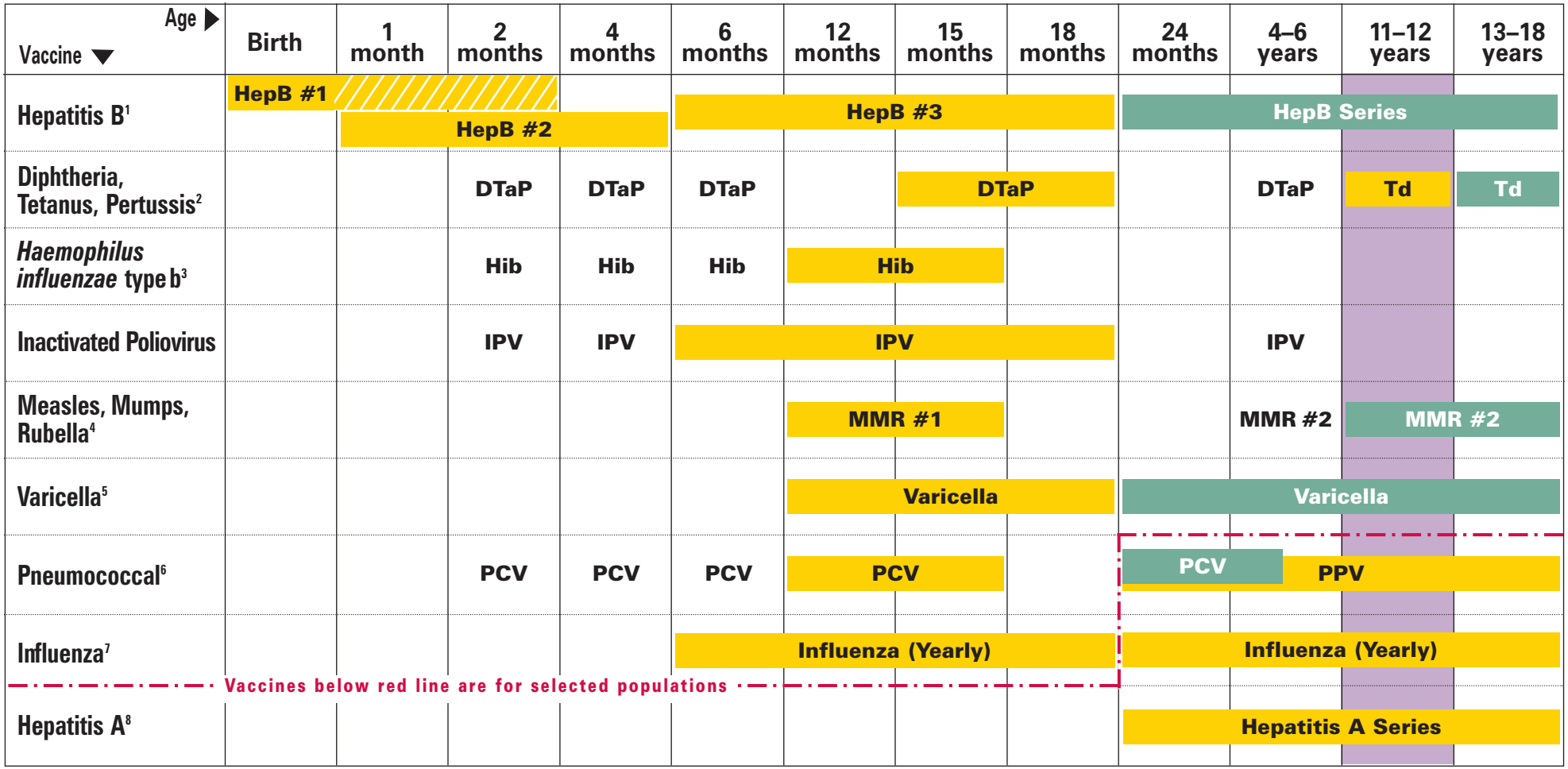
RISK FACTORS

1. Infant with Low Birth Weight
2. Infant/Child who is Drug-Exposed
3. Infant/Child Diagnosed with Failure to Thrive
4. Child with Developmental Delay
5. Child with Nutritional Deficiency
6. Child with Long-Term Chronic Illness
7. Child with Diagnosed Handicapping Condition
8. Child Unwanted or at risk for Poor Bonding
9. Parent with Negative or Ambivalent Attitude regarding Pregnancy or Parenting
10. Parent who Perceives Child as Difficult
11. Parent who Perceives Harsh Punishment of Child as Appropriate
12. Parent with Rigid and Unrealistic Expectations of Child's Behavior
13. Parent with Diagnosed Physical Condition that Interferes with Parenting Ability
14. Parent with Serious Mental Disturbance
15. Parent with Low Self Esteem and/or Depression
16. Parent with Learning Disability
17. Parent who is Emotionally Immature
18. Parent with Destructive or Violent Temperament
19. Parent with Substance Abuse or Addiction
20. Parent with Language Deficiency or Immaturity
21. Non-English or Limited English Speaking Household
22. Family History of Low School Achievement or Dropout
23. Family History of Child Abuse
24. Family History of Delinquency
25. Family History of Diagnosed Family Problems
26. Low Parental/Sibling Educational Attainment or Illiteracy
27. Family with Multiple Crises or Stresses
28. Family with Marital/Partner Conflict
29. Family with Extended Family Conflict
30. Family with Housing Problems
31. Family in an Unsafe Living Environment
32. Family who is Homeless
33. Family who is Isolated with Inadequate Support System
34. Single Parent
35. Unemployed Parents
36. Low Family Income
37. Teen Parent
38. Family with a Large Number of Children or Closely Spaced Young Children
39. Family with Incarcerated Parents
40. Other

Attachment C:

Recommended Childhood and Adolescent Immunization Schedule

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2005



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2004, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible.

Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form can be found on the Internet: www.vaers.org or by calling 800-822-7967.

- Range of recommended ages
- Only if mother HBsAg(–)
- Preadolescent assessment
- Catch-up immunization

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC SAFER·HEALTHIER·PEOPLE™

The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices www.cdc.gov/nip/acip
American Academy of Pediatrics www.aap.org
American Academy of Family Physicians www.aafp.org

Footnotes

Recommended Childhood and Adolescent Immunization Schedule

UNITED STATES • 2005

1. **Hepatitis B (HepB) vaccine.** All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is hepatitis B surface antigen (HBsAg) negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks.

   Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL of Hepatitis B Immune Globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9–15 months.

   Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks.

2. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.** The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11–12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. ***Haemophilus influenzae* type b (Hib) conjugate vaccine.** Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB or ComVax [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters following any Hib vaccine. The final dose in the series should be given at age ≥12 months.

4. **Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the visit at age 11–12 years.

5. **Varicella vaccine.** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses, given at least 4 weeks apart.

6. **Pneumococcal vaccine.** The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months. It is also recommended for certain children aged 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(RR-9):1-35.

7. **Influenza vaccine.** Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, and diabetes), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2004;53[RR-6]:1-40) and can be administered to all others wishing to obtain immunity. In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–23 months are recommended to receive influenza vaccine, because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2004;53(RR-6):1-40. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if 6–35 months or 0.5 mL if ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

8. **Hepatitis A vaccine.** Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A immunization series during any visit. The 2 doses in the series should be administered at least 6 months apart. See *MMWR* 1999;48(RR-12):1-37.

Recommended Immunization Schedule
for Children and Adolescents Who Start Late or Who Are More Than 1 Month Behind
UNITED STATES • 2005

The tables below give catch-up schedules and minimum intervals between doses for children who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.

CATCH-UP SCHEDULE FOR CHILDREN AGED 4 MONTHS THROUGH 6 YEARS

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Diphtheria, Tetanus, Pertussis	6 wks	4 weeks	4 weeks	6 months	6 months[1]
Inactivated Poliovirus	6 wks	4 weeks	4 weeks	4 weeks[2]	
Hepatitis B[3]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Measles, Mumps, Rubella	12 mo	4 weeks[4]			
Varicella	12 mo				
Haemophilus influenzae type b[5]	6 wks	4 weeks if first dose given at age <12 months 8 weeks (as final dose) if first dose given at age 12-14 months No further doses needed if first dose given at age ≥15 months	4 weeks[6] if current age <12 months 8 weeks (as final dose)[6] if current age ≥12 months and second dose given at age <15 months No further doses needed if previous dose given at age ≥15 mo	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal[7]	6 wks	4 weeks if first dose given at age <12 months and current age <24 months 8 weeks (as final dose) if first dose given at age ≥12 months or current age 24–59 months No further doses needed for healthy children if first dose given at age ≥24 months	4 weeks if current age <12 months 8 weeks (as final dose) if current age ≥12 months No further doses needed for healthy children if previous dose given at age ≥24 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	

CATCH-UP SCHEDULE FOR CHILDREN AGED 7 YEARS THROUGH 18 YEARS

Vaccine	Minimum Interval Between Doses		
	Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Booster Dose
Tetanus, Diphtheria	4 weeks	6 months	**6 months**[8] if first dose given at age <12 months and current age <11 years **5 years**[8] if first dose given at age ≥12 months and third dose given at age <7 years and current age ≥11 years **10 years**[8] if third dose given at age ≥7 years
Inactivated Poliovirus[9]	4 weeks	4 weeks	IPV[2,9]
Hepatitis B	4 weeks	8 weeks (and 16 weeks after first dose)	
Measles, Mumps, Rubella	4 weeks		
Varicella[10]	4 weeks		

Footnotes

Children and Adolescents Catch-up Schedules

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1. **DTaP.** The fifth dose is not necessary if the fourth dose was given after the fourth birthday.
2. **IPV.** For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was given at age ≥4 years. If both OPV and IPV were given as part of a series, a total of 4 doses should be given, regardless of the child's current age.
3. **HepB.** All children and adolescents who have not been immunized against hepatitis B should begin the HepB immunization series during any visit. Providers should make special efforts to immunize children who were born in, or whose parents were born in, areas of the world where hepatitis B virus infection is moderately or highly endemic.
4. **MMR.** The second dose of MMR is recommended routinely at age 4–6 years but may be given earlier if desired.
5. **Hib.** Vaccine is not generally recommended for children aged ≥5 years.
6. **Hib.** If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB or ComVax [Merck]), the third (and final) dose should be given at age 12–15 months and at least 8 weeks after the second dose.
7. **PCV.** Vaccine is not generally recommended for children aged ≥5 years.
8. **Td.** For children aged 7–10 years, the interval between the third and booster dose is determined by the age when the first dose was given. For adolescents aged 11–18 years, the interval is determined by the age when the third dose was given.
9. **IPV.** Vaccine is not generally recommended for persons aged ≥18 years.
10. **Varicella.** Give 2-dose series to all susceptible adolescents aged ≥13 years.

Report adverse reactions to vaccines through the federal Vaccine Adverse Event Reporting System. For information on reporting reactions following immunization, please visit www.vaers.org or call the 24-hour national toll-free information line 800-822-7967. Report suspected cases of vaccine-preventable diseases to your state or local health department.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Web site at www.cdc.gov/nip or call the National Immunization Information Hotline at 800-232-2522 (English) or 800-232-0233 (Spanish).

Attachment D:

Recommendations for Preventive Pediatric Health Care

Recommendations for Preventive Pediatric Health Care (RE9535)

Committee on Practice and Ambulatory Medicine

Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of **continuity of care** in comprehensive health supervision and the need to avoid **fragmentation of care.**

	INFANCY[4]									EARLY CHILDHOOD[4]					MIDDLE CHILDHOOD[4]				ADOLESCENCE[4]										
AGE[5]	PRENATAL[1]	NEWBORN[2]	2-4d[3]	By 1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y	21y
HISTORY Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS Height and Weight		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference		•	•	•	•	•	•	•	•	•	•	•																	
Blood Pressure													•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING Vision		S	S	S	S	S	S	S	S	S	S	S	O[6]	O	O	O	O	O	S	O	S	S	O	S	S	O	S	S	S
Hearing		O[7]	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	S	O	S	S	O	S	S	O	S	S	S
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT[8]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION[9]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES-GENERAL[10]																													
Hereditary/Metabolic Screening[11]		◄	●	►																									
Immunization[12]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hematocrit or Hemoglobin[13]								•	►	★	◄	●	►						◄	●	[14]	►							
Urinalysis															•				◄	●	►			[15]	►				
PROCEDURES-PATIENTS AT RISK																													
Lead Screening[16]								★	►			★																	
Tuberculin Test[17]									★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Cholesterol Screening[18]												★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
STD Screening[19]																			★	★	★	★	★	★	★	★	★	★	★
Pelvic Exam[20]																			★	★	★	★	★	★	★	★	◄	★	► ★
ANTICIPATORY GUIDANCE[21]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Injury Prevention[22]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Violence Prevention[23]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Sleep Positioning Counseling[24]	•	•	•	•	•	•	•																						
Nutrition Counseling[25]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DENTAL REFERRAL[26]									◄				●	►															

1. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (1996).
2. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged and instruction and support offered. Every breastfeeding infant should have an evaluation 48-72 hours after discharge from the hospital to include weight, formal breastfeeding evaluation, encouragement, and instruction as recommended in the AAP statement "Breastfeeding and the Use of Human Milk" (1997).
3. For newborns discharged in less than 48 hours after delivery per AAP statement "Hospital Stay for Healthy Term Newborns" (1995).
4. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
5. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
6. If the patient is uncooperative, rescreen within 6 months.
7. All newborns should be screened per the AAP Task Force on Newborn and Infant Hearing statement, "Newborn and Infant Hearing Loss: Detection and Intervention" (1999).
8. By history and appropriate physical examination: if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
9. At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
10. These may be modified, depending upon entry point into schedule and individual need.
11. Metabolic screening (eg, thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
12. Schedule(s) per the Committee on Infectious Diseases, published annually in the January edition of *Pediatrics*. Every visit should be an opportunity to update and complete a child's immunizations.
13. See AAP *Pediatric Nutrition Handbook* (1998) for a discussion of universal and selective screening options. Consider earlier screening for high-risk infants (eg, premature infants and low birth weight infants). See also "Recommendations to Prevent and Control Iron Deficiency in the United States. *MMWR*. 1998;47 (RR-3):1-29.
14. All menstruating adolescents should be screened annually.
15. Conduct dipstick urinalysis for leukocytes annually for sexually active male and female adolescents.
16. For children at risk of lead exposure consult the AAP statement "Screening for Elevated Blood Levels" (1998). Additionally, screening should be done in accordance with state law where applicable.
17. TB testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases*. Testing should be done upon recognition of high-risk factors.
18. Cholesterol screening for high-risk patients per AAP statement "Cholesterol in Childhood" (1998). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
19. All sexually active patients should be screened for sexually transmitted diseases (STDs).
20. All sexually active females should have a pelvic examination. A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.
21. Age-appropriate discussion and counseling should be an integral part of each visit for care per the AAP *Guidelines for Health Supervision III* (1998).
22. From birth to age 12, refer to the AAP injury prevention program (TIPP®) as described in *A Guide to Safety Counseling in Office Practice* (1994).
23. Violence prevention and management for all patients per AAP Statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level" (1999).
24. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS. Consult the AAP statement "Positioning and Sudden Infant Death Syndrome (SIDS): Update" (1996).
25. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP *Handbook of Nutrition* (1998).
26. Earlier initial dental examinations may be appropriate for some children. Subsequent examinations as prescribed by dentist.

Key: ● = to be performed ★ = to be performed for patients at risk
S = subjective, by history O = objective, by a standard testing method
◄—●—► = the range during which a service may be provided, with the dot indicating the preferred age.

NB: Special chemical, immunologic, and endocrine testing is usually carried out upon specific indications. Testing other than newborn (eg, inborn errors of metabolism, sickle disease, etc) is discretionary with the physician.

American Academy of Pediatrics

Attachment E:

Recommendations for the Number of Prenatal Care Visits

American College of Obstetricians and Gynecologists

Recommended Prenatal Visit Schedule:

For a full-term (40-week) pregnancy with no complications,
ACOG recommends prenatal-care visits:

- Every 4 weeks for the first 28 weeks of pregnancy,
- Every 2-3 weeks until 36 weeks of gestation,
- and weekly, thereafter, although flexibility is desirable.

Note: The frequency and complexity of these visits may vary, according to previous obstetrical history, and any special needs that the mother and baby may have.

0-3 Secondary Prevention Programs
Data Collection Form
(formerly known as the program register)
Fiscal Year 2005-2006

1. Contact Information

CTF Grant Monitor Approval_____

Name of Program/Agency:_____ County(ies) Served:_____

Program Telephone Number: ( ) _____ Quarter of the Year: ____ 1st ____ 2nd ____ 3rd ____ 4th

Date Forwarded: Completed By:_____
(Print or Type Name)

2. Participant Data (for all programs/services funded by the 0-3 grant)		**Quarterly Services & Year-To-Date Totals**							
		1st	YTD	2nd	YTD	3rd	YTD	4th	YTD
A. Number of Families from Previous Quarter Continuing in Services*									
B. Number of Families Screened			0		0		0		0
C. Number of Families Assessed			0		0		0		0
D. Number of Newly Enrolled Families			0		0		0		0
E. Total Number of Families Served *									
F. Number of Newly Enrolled age 0-3 Children			0		0		0		0
G. Total Number of Children age 0-3 Served *									
H. Number of Newly Enrolled Pregnant Women (if applicable)			0		0		0		0
I. Total Number of Pregnant Women Served (if applicable) *									
J. Number of Families Served with 3 or more Risk Factors*									
K. Number of Families who "aged out"			0		0		0		0
L. Number of Families Completing Service			0		0		0		0
M. Number of Families Transitioned to Other Services			0		0		0		0
N. Number of Families who Dropped Out of Services									
a. Number of families who are no longer interested in service			0		0		0		0
b. Number of families that are unable to be located			0		0		0		0
c. Other (please specify) _____			0		0		0		0
d. Other (please specify) _____			0		0		0		0
3. Race/Ethnicity of Children Served		1st		2nd		3rd		4th	
Race: Black or African-American	Child								
Race: Hispanic or Latin-American	Child								
Race: White or Caucasian	Child								
Race: Multi-Racial	Child								
Other Race (Please Specify): _____	Child								
4. Services Provided		1st	YTD	2nd	YTD	3rd	YTD	4th	YTD
A. Home Visits			0		0		0		0
B. Parenting Classes			0		0		0		0
C. Parent Support Groups			0		0		0		0
D. Service Coordination			0		0		0		0
E. Child Care Services			0		0		0		0
F. Respite Care Services			0		0		0		0
G. Transportation			0		0		0		0
H. One-on-one counseling			0		0		0		0
I.1 Other Service: Phone Contacts			0		0		0		0
I.2 Other Service: Developmental Newsletters			0		0		0		0
I.3 Other Service: Developmental Assessments/Screenings			0		0		0		0
I.4 Other Service:(Specify):			0		0		0		0

5. Outcome Data		1st		2nd		3rd		4th	
A. Number and percentage of families who have a primary health care provider	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
B. Number and percentage of 0-3 age children who are up-to-date with age-appropriate immunizations	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
C. Number and percentage of 0-3 age children who are up-to-date with well-child visits	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
D. Number and percentage of pregnant women who received the recommended number of prenatal visits	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
E. Number and percentage of 0-3 age children who participated in developmental screening during the quarter	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
F. Number and percentage of 0-3 age children who met age-appropriate developmental milestones	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
G. Number and percentage of 0-3 age children who did not meet age appropriate developmental milestones	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
a. Number and percentage of 0-3 age children with a suspected developmental delay who were referred to appropriate services	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
b. Number and percentage of families who followed through with the referral(s) to appropriate developmental services	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
6. If a participant satisfaction survey was completed this quarter, complete the following:									
A. Number and percentage of families sent the satisfaction survey	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
B. Number and percentage of families responding to the satisfaction survey	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
C. Number and percentage of families who were satisfied with 0-3 services	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
D. Number and percentage of families who reported that their parenting skills improved as a result of the 0-3 service(s)	#								
	%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	

Guidelines for Locally Implemented Annual Evaluations for Grantees of the State of Michigan's Zero to Three Secondary Prevention Initiative

Compiled by Michael D. Gillespie, MSW - Gillespie Research, LLC

All Zero to Three Secondary Prevention Initiative (0-3) Grantees are required to conduct an annual locally implemented evaluation[1]. This evaluation should be in addition to the evaluation data required by the funding agencies and the Michigan Children's Trust Fund. Moreover, this evaluation should be both a quantitative and qualitative reflection of the grantee's impact on the local community, and the community and/or county's impact on the prevention of child abuse and neglect.

While the data that each grantee collects for the required state-level evaluation[2] of 0-3 is used by the initiative evaluator for legislative and other reporting requirements, these localized evaluations are for the purpose of informing grant monitors and administrators about the successes, challenges, and processes of grantees and their programs. Further, these local evaluations can be used in grant reviews, to holistically inform future grant applications, and to empower and support the larger state-level evaluation with in-depth localized information.

With this stated, the local evaluation does not have to be a daunting task. It does not require clinical trials utilizing "double-blind" comparison groups and other such scientific processes. Historically, some grantees have chosen to contract with an external evaluator but this is not required: a perfectly feasible, valid, and acceptable evaluation can be conducted without such assistance. This document is meant to act as a guide for those grantees unable to contract with an outside evaluator, and for those that do, to meet the requirements of 0-3 Grant Monitors. This document will not offer set parameters for page lengths or font size, nor will it layout requirements for the types of charts and graphs one should use in developing a report. Instead, this document, in its brevity, will offer suggestions for the types of information and data points that 0-3 Grant Monitors will look for when reviewing evaluation reports.

[1] Please refer to the Zero to Three Secondary Prevention Grant Agreement, Evaluation Section, Subsection A

[2] State-level evaluation requirements include: the Adult-Adolescent Parenting Inventory, Quarterly Data Collection Form Submissions, 31-B Forms for CPS Involvement, and the use of the Zero to Three Secondary Prevention Initiative Indicators.

Unlike traditional evaluation reports replete with statistical and technical jargon, the local annual evaluation should focus more on a reflective "self-evaluation". The local evaluation should be a culmination of the program's year and include a discussion of program processes, data, and outcomes, which leads to a qualitative and reflexive evaluation on how this information will help improve the program.

Because the initiative collects a substantial amount of quantitative data, the focus of the local evaluation is not on what the data are saying. More important, the focus should be on how the program summarizes their own data, how the data highlight successes and challenges of the year, and what implications the data have for the program in the coming year.

At a minimum, local evaluation reports to 0-3 Grant Monitors should include the following four sections:

1) An introductory section that outlines the contents of the report, including a program description, data collection tools, data collection methods, and general findings/conclusions.
   a) This is important as it offers space to highlight important information in the report.
   b) One may consider this component similar to an "executive summary" but the reader should be able to understand the program by reading the introduction.

2) A section that highlights both success and challenges of the year evident through a review of program data[3].
   a) Use data descriptively and organize key information.
      i) Quantitative analysis does not have to be difficult; simple frequencies and averages are often effective enough.
   b) Discuss the data in the context of what it means for your program. Why are the data important?
      i) Clarity, not complexity, makes for effective data analysis.
   c) Discuss the success and challenges based on the data.

3) A section that focuses on other program information that is not apparent through the data.
   a) What happened during the year that helped or hindered the delivery of the program?

[3] Program data includes the required data collected for the state-level evaluation as well as other data and information collected locally, but not reported in other formats to the initiative. One important component is the results of the parent/client satisfaction survey. Because minimal information is required quarterly from the satisfaction survey, this is an opportunity to highlight other findings from the survey. The parent/client satisfaction survey is an effective tool to use as the foundation of the local evaluation. It certainly does not have to be limited to satisfaction and could be the only other data collected for this purpose.

4) The final component should focus on a summary of the data and other program information in the context of continuous improvement and program planning.
    a) Ultimately, this is where the report will present how the information presented in the previous sections will impact the future of the program.
    b) Specifically, it moves from what the data are saying to what the program is learning, expanding, and changing because of the data.
    c) This section should, minimally, set the direction for program implementation in the following grant year, and inform the local program, grant monitors, and administrators of the direction of the program.

Technical Assistance with Local Program Evaluations:

Contact your grant monitor!
Jeff Sadler, Michigan Children's Trust Fund
517.335.4620
sadlerm@michigan.gov

Dawn Ritter, Michigan Department of Human Services
517.335.0650
ritterd@michigan.gov

For technical assistance with conducting evaluations and collecting data, contact the 0-3 Evaluation Consultant:
Michael Gillespie, Gillespie Research, LLC
248.912.0278
michael@gillespieresearch.org